STATEMENT OF EMERGENCY

907 KAR 13:010E

(1) This emergency administrative regulation is being promulgated in conjunction with two (2) other administrative regulations – 907 KAR 13:005E, Definitions for KAR Chapter 13 and 907 KAR 13:015E, Private duty nursing service reimbursement provisions and requirements - to comply with an Affordable Care Act mandate. The three (3) administrative regulations are necessary to establish Kentucky Medicaid Program coverage and reimbursement of private duty nursing services. Private duty nursing services are a new benefit for Kentucky's Medicaid Program required as the benefit is covered in the "alternative benefit plan" adopted by Kentucky for Kentucky's Health Benefit (or Insurance) Exchange and for all Kentucky Medicaid recipients effective January 1, 2014. Additionally, the amended administrative regulation is being promulgated to establish that Medicaid Program reimbursement of the services under this administrative regulation is contingent upon the receipt of federal approval and federal funding in order to prevent expending Kentucky taxpayer funds when federal matching funds are not provided.

(2) This action must be taken on an emergency basis to comply with a federal mandate and to prevent a potential loss of state funds.

(3) This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler.

(4) The ordinary administrative regulation is identical to this emergency administrative regulation.

_____
Steven L. Beshear
Governor

_____
Audrey Tayse Haynes, Secretary
Cabinet for Health and Family Services

CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Policy and Operations

(New Emergency Administrative Regulation)

907 KAR 13:010E. Private duty nursing service coverage provisions and requirements.

RELATES TO: KRS 205.520

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 C.F.R. 440.80, 440.330, and 42 U.S.C. 1396u-7.

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has a responsibility to administer the Medicaid program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. This administrative regulation establishes the Medicaid Program coverage provisions and requirements regarding private duty nursing services.

Section 1. Provider Participation. (1) To be eligible to provide services under this administrative regulation a provider shall be:

(a) Currently enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672;

(b) Except as established in subsection (2) of this section, currently participating in the Kentucky Medicaid Program in accordance with 907 1:671; and

(c)1. A private duty nursing agency; or

2. A home health agency licensed in accordance with 902 KAR 20:370 to provide private duty nursing services.

(2) In accordance with Section 3(3) of 907 KAR 17:010, a provider of a service to an enrollee shall not be required to be currently participating in the Medicaid program if the managed care organization in which the enrollee is enrolled does not require the provider to be currently participating in the Medicaid program.

Section 2. Coverage and Limit. (1) The department shall reimburse for a private duty nursing service if the service is:

(a) Provided:

1. By a:

a. Registered nurse employed by a:

(i) Private duty nursing agency that meets the requirements established in Section 3 of this administrative regulation; or

(ii) Home health agency that meets the requirements established in Section 3 of this administrative regulation; or

b. Licensed practical nurse employed by a:

(i) Private duty nursing agency that meets the requirements established in Section 3 of this administrative regulation; or

(ii) Home health agency that meets the requirements established in Section 3 of this administrative regulation;

2. To a recipient in the recipient's home, except as provided in subsection (2) of this section; and

3. Under the direction of the recipient's physician in accordance with 42 C.F.R. 440.80;

(b)1. Prescribed for the recipient by a physician; and

2. Stated in the recipient's plan of treatment developed by the prescribing physician;

(c) Established as being needed for the recipient in the recipient's home;

(d) Prior authorized; and

(e) Medically necessary.

(2) A private duty nursing service may be covered in a setting other than in the recipient's home, if the service is provided during a normal life activity of the recipient that requires the recipient to be out of his or her home.

(3)(a) There shall be an annual limit of private duty nursing services per recipient of 2,000 hours.

(b) The limit established in paragraph (a) of this subsection may be exceeded if services in excess of the limit are determined to be medically necessary.

Section 3. No Duplication of Service. The department shall not reimburse for any of the following services providing during the same time that a private duty nursing service is provided to a recipient:

(1) A personal care service;

(2) A skilled nursing service or visit; or

(3) A home health aide service.

Section 4. Conflict of Interest. The department shall not reimburse for a private duty nursing service provided to a recipient if the individual providing the service is:

(1) An immediate family member of the recipient; or

(2) A legally responsible individual who maintains his or her primary residence with the recipient.

Section 5. Records Maintenance, Protection, and Security. (1)(a) A provider shall maintain a current health record for each recipient.

(b)1. A health record shall document each service provided to the recipient including the date of the service and the signature of the individual who provided the service.

2. The individual who provided the service shall date and sign the health record on the date that the individual provided the service.

(2)(a) A provider shall maintain a health record regarding a recipient for at least five (5) years from the date of the service.

(b) If the United States Department of Health and Human Services secretary requires a longer document retention period than the period referenced in paragraph (a) of this section, pursuant to 42 CFR 431.17, the period established by the secretary shall be the required period.

(3) A provider shall comply with 45 Chapter 164.

Section 6. Medicaid Program Participation Compliance. (1) A provider shall comply with:

(a) 907 KAR 1:671;

(b) 907 KAR 1:672; and

(c) All applicable state and federal laws.

(2)(a) If a provider receives any duplicate payment or overpayment from the department, regardless of reason, the provider shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this section may be:

1. Interpreted to be fraud or abuse; and

2. Prosecuted in accordance with applicable federal or state law.

Section 7. Third Party Liability. A provider shall comply with KRS 205.622.

Section 8. Use of Electronic Signatures. (1) The creation, transmission, storage, and other use of electronic signatures and documents shall comply with the requirements established in KRS 369.101 to 369.120.

(2) A provider that chooses to use electronic signatures shall:

(a) Develop and implement a written security policy that shall:

1. Be adhered to by each of the provider's employees, officers, agents, or contractors;

2. Identify each electronic signature for which an individual has access; and

3. Ensure that each electronic signature is created, transmitted, and stored in a secure fashion;

(b) Develop a consent form that shall:

1. Be completed and executed by each individual using an electronic signature;

2. Attest to the signature's authenticity; and

3. Include a statement indicating that the individual has been notified of his responsibility in allowing the use of the electronic signature; and

(c) Provide the department with:

1. A copy of the provider's electronic signature policy;

2. The signed consent form; and

3. The original filed signature immediately upon request.

Section 9. Auditing Authority. The department shall have the authority to audit any claim or medical record or documentation associated with any claim or medical record.

Section 10. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the coverage; and

(2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 11. Appeals. (1) An appeal of an adverse action by the department regarding a service and a recipient who is not enrolled with a managed care organization shall be in accordance with 907 KAR 1:563.

(2) An appeal of an adverse action by a managed care organization regarding a service and an enrollee shall be in accordance with 907 KAR 17:010.

907 KAR 13:010E

REVIEWED:

Date

Lawrence Kissner, Commissioner
Department for Medicaid Services

APPROVED:

Date

Audrey Tayse Haynes, Secretary
Cabinet for Health and Family Services

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation Number: 907 KAR 13:010E
Cabinet for Health and Family Services
Department for Medicaid Services
Agency Contact: Stuart Owen (502) 564-4321

(1) Provide a brief summary of:

(a) What this administrative regulation does: This is a new administrative regulation which establishes the provisions and requirements regarding Medicaid Program private duty nursing services. These are new services being covered by the Department for Medicaid Services (DMS) resulting from DMS's implementation of an alternative benefit plan (based on a "benchmark" or "benchmark equivalent plan") as required by the Affordable Care Act. Any state which expands its Medicaid eligibility groups to include the "expansion group" authorized by the Affordable Care Act is required to establish an alternative benefit plan for the expansion group. The expansion group is comprised primary of adults under age sixty-five (65) who are not pregnant, who have income below 133 percent of the federal poverty level, and who are not otherwise eligible for Medicaid benefits. An alternative benefit plan has to be based on a "benchmark" or "benchmark-equivalent plan." There are four (4) acceptable such plans as established by 42 C.F.R. 440.330 and 42 U.S.C. 1396u-7(b). The four (4) are:

- The benefit plan provided by the Federal Employees Health Benefit plan Standard Blue Cross/Blue Shield Provider Option;
- The state employer health coverage that is offered and generally available to state employees;
- The health insurance plan offered through the Health Maintenance Organization (HMO) with the largest insured commercial non-Medicaid enrollment in the state; and
- Secretary-approved coverage, which is a benefit plan that the secretary has determined to provider coverage appropriate to meet the needs of the population provided that coverage.

States are required to cover every service in the given alternative benefit plan and may not pick and choose services from different alternative benefit plan options.

The benchmark plan or benchmark equivalent plan is also the plan for the state's health benefit exchange. A health benefit exchange (also referred to as a health insurance exchange or "affordable insurance exchange") is mandated for each state by the Affordable Care Act. The health benefit exchange is a marketplace of health insurance plans. Individuals whose income is within the threshold of qualifying to purchase health insurance through the health benefit exchange can do so and the government will help subsidize the cost of the individual's health insurance premiums.

Each state is required to establish a benchmark plan or benchmark equivalent plan for its health benefit exchange. States who add the Medicaid expansion group, authorized by the Affordable Care Act, to its Medicaid Program coverage are required to use the same “benchmark” or “benchmark equivalent plan” as the health benefit exchange to establish the alternative benefit plan for the Medicaid expansion group.

Kentucky selected a benchmark plan that is in the category of Health and Human Services Secretary-approved coverage. The specific plan is the Anthem Blue Cross Blue Shield Small Group Provider Preferred Option (PPO). As this plan includes private duty nursing services as a benefit, DMS is required to cover private duty nursing services. DMS’s benefit plan will be the same for all Medicaid recipients – existing populations as well as new eligibility groups authorized or mandated by the Affordable Care Act. DMS is promulgating this new administrative regulation in conjunction with two (2) accompanying private duty nursing service administrative regulations – 907 KAR 13:010E, private duty nursing service coverage provisions and requirements and 907 KAR 13:015E, reimbursement for private duty nursing services.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the definitions for administrative regulations located in Chapter 13 of Title 907 of the Kentucky Administrative Regulations. Chapter 13 contains Medicaid administrative regulations regarding private duty nursing services.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing the definitions for administrative regulations located in Chapter 13 of Title 907 of the Kentucky Administrative Regulations. Chapter 13 contains Medicaid administrative regulations regarding private duty nursing services.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the authorizing statutes by establishing the definitions for administrative regulations located in Chapter 13 of Title 907 of the Kentucky Administrative Regulations. Chapter 13 contains Medicaid administrative regulations regarding private duty nursing services.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation rather than an amendment to an existing administrative regulation.
(d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: There are currently thirteen (13) private duty nursing agencies licensed in Kentucky and 109 home health agencies licensed in Kentucky.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:
(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment. A private duty nursing agency that wishes to provide services to Medicaid recipients will need to enroll with the Medicaid Program as prescribed in the Medicaid provider enrollment regulation (complete and application and submit it to DMS) and sign agreements with managed care organizations if the agency wishes to provide services to Medicaid recipients who are enrolled with a managed care organization. A home health agency that wishes to provide Medicaid-covered private duty nurse services must obtain a private duty nursing agency licensed from the Cabinet for Health and Family Services, Office of Inspector General in accordance with 902 KAR 20:370 and also enroll with the Medicaid Program as mentioned above for private duty nursing agencies.
(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). A private duty nursing agency could experience administrative cost associated with enrolling in the Medicaid Program. A home health agency which wishes to provide private duty nursing services could experience administrative costs associated with obtaining a private duty nursing agency license from the Cabinet for Health and Family Services, Office of Inspector General as well as administrative costs associated with enrolling with the Medicaid Program.
(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). A private duty nursing agency that enrolls with the Medicaid Program and provide services to Medicaid recipients in accordance with this administrative regulation will benefit by being reimbursed for the services. Likewise, a home health agency that takes the requisite steps will benefit by being reimbursed by the Medicaid Program for private duty nursing services.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: DMS estimates that its cost associated with covering private duty nursing services will be $12.87 million ($2.44 million in state funds and $10.43 million in federal funds) for state fiscal year 2014.
(b) On a continuing basis: DMS estimates that its annual cost, beginning with state fiscal year 2015, associated with covering private duty nursing services will be $17.17 million ($3.26 million in state funds and $13.91 million in federal funds.)

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX of the Social Security Act and matching funds of general fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment. Neither an increase in fees nor funding is necessary to implement this administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation neither establishes nor increases any fees.

(9) Tiering: Is tiering applied? (Explain why tiering was or was not used.) Tiering is not applied as the policies apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

Regulation Number: 907 KAR 13:010E
Agency Contact: Stuart Owen (502) 564-4321

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396u-7(b).

2. State compliance standards. KRS 205.520(3) states:

"Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect."

3. Minimum or uniform standards contained in the federal mandate. Medicaid programs are not required to cover private duty nursing services; however, any Medicaid program which adds, to its eligible population, the "expansion group" authorized by the Affordable Care Act, must establish an alternative benefit plan for the expansion group.

The expansion group is a new eligibility category comprised of adults below age sixty-five (65), with income below 133% of the federal poverty level, who are not pregnant, and who do not otherwise qualify for Medicaid.

An alternative benefit plan has to be based on a "benchmark" or "benchmark-equivalent package." There are four (4) acceptable such packages as established by 42 C.F.R. 440.330 and 42 U.S.C. 1396u-7(b). The four (4) are:

- The benefit package provided by the Federal Employees Health Benefit plan Standard Blue Cross/Blue Shield Provider Option;
- The state employer health coverage that is offered and generally available to state employees;
- The health insurance plan offered through the Health Maintenance Organization (HMO) with the largest insured commercial non-Medicaid enrollment in the state; and
- Secretary-approved coverage, which is a benefit package the secretary has determined to provider coverage appropriate to meet the needs of the population provided that coverage.

States are required to cover every service in the given alternative benefit plan and may not pick and choose services from different alternative benefit plan options.

The alternative benefit plan is also the plan for the state's health benefit exchange. A health benefit exchange (also referred to as a health insurance exchange or "affordable insurance exchange") is mandated for each state by the Affordable Care Act. The health benefit exchange is a marketplace of health insurance plans. Individuals whose income is within the threshold of qualifying to purchase health insurance through the health

benefit exchange can do so and the government will help subsidize the cost of the individual's health insurance premiums.

Each state is required to establish an alternative benefit plan (plan of health care services covered) for its health benefit exchange. States who add the Medicaid expansion group, authorized by the Affordable Care Act, to its Medicaid Program coverage are required to have the same alternative benefit plan for the health benefit exchange as for the Medicaid expansion group.

Kentucky selected an alternative benefit plan that is in the category of Health and Human Services Secretary-approved coverage. The specific plan is the Anthem Blue Cross Blue Shield Small Group Provider Preferred Option (PPO). As this plan includes private duty nursing services as a benefit, DMS is required to cover private duty nursing services. DMS is adopting the same benefit plan for all Medicaid recipients; thus, private duty nursing services will be covered for all Medicaid recipients who meet the coverage criteria.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? The administrative regulation does not impose stricter than federal requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. The administrative regulation does not impose stricter than federal requirements.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Regulation Number: 907 KAR 13:010E
Agency Contact: Stuart Owen (502) 564-4321

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services will be affected by the amendment to this administrative regulation. As some home health agencies are owned by local governments, any such agency could be affected if it chooses to procure a private duty nursing license from the Cabinet for Health and Family Services, Office of Inspector General and enroll with the Medicaid Program.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. 42 C.F.R. 440.80, 42 C.F.R. 440.330, and this administrative regulation authorize the action taken by this administrative regulation.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? This administrative regulation could generate revenue for some local governments as there are home health agencies in Kentucky owned by a local government entity. If any such entity elected to obtain a private duty nursing license from the Cabinet for Health and Family Services, Office of Inspector General and enroll with the Medicaid Program the entity could receive revenues in the form of Medicaid reimbursement for private duty nursing services. The revenues are indeterminable as the Department for Medicaid Services cannot accurately predict how many such entities would take the requisite steps.
(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? The amendment is not expected to generate revenue for state or local government. The response to question (a) also applies here.
(c) How much will it cost to administer this program for the first year? DMS estimates that its cost associated with covering private duty nursing services will be $12.87 million ($2.44 million in state funds and $10.43 million in federal funds) for state fiscal year 2014.
(d) How much will it cost to administer this program for subsequent years? DMS estimates that its annual cost, beginning with state fiscal year 2015, associated with covering private duty nursing services will be $17.17 million ($3.26 million in state funds and $13.91 million in federal funds.)

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):
Expenditures (+/-):
Other Explanation: